NCLEX-RN®
DETAILED
TEST PLAN

Effective | April 2016

NCLEX-RN® Examination

Detailed Test Plan for the National Council Licensure Examination for Registered Nurses

Candidate Version

NCSBN
National Council of State Boards of Nursing

Mission Statement

The National Council of State Boards of Nursing (NCSBN®) provides education, service and research through collaborative leadership to promote evidenced-based regulatory excellence for patient safety and public protection.

Purpose and Functions

The purpose of the National Council of State Boards of Nursing (NCSBN) is to provide an organization through which boards of nursing act and counsel together on matters of common interest and concern affecting the public health, safety and welfare, including the development of licensing examinations in nursing.

The major functions of NCSBN include developing the NCLEX-RN® and NCLEX-PN® examinations, performing policy analysis and promoting uniformity in relationship to the regulation of nursing practice, disseminating data related to NCSBN's purpose, and serving as a forum for information exchange for NCSBN members.

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National Council of State Boards of Nursing

2016 NCLEX-RN® Detailed Test Plan

Candidate Version

Effective Date
April 2016

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I. Background

The Candidate Detailed Test Plan for the National Council Licensure Examination for Registered Nurses (NCLEX-RN®) was developed by the National Council of State Boards of Nursing, Inc (NCSBN®). The purpose of this document is to provide more detailed information about the content areas tested in the NCLEX-RN Examination than is provided in the basic NCLEX-RN Test Plan.

This booklet contains the:

- *2016 NCLEX-RN® Test Plan*;
- Information on testing requirements and sample examination questions (items); and
- Bibliography.

About the NCLEX-RN® Test Plan (Section II)

The test plan is reviewed and approved by the NCLEX® Examination Committee every three years. Multiple resources are used, including the recent practice analysis of registered nurses, and expert opinions of the Examination Committee, NCSBN content staff, and boards of nursing (NCSBN's Member Boards) to ensure that the test plan is consistent with state nurse practice acts. Following the endorsement of proposed revisions by the Examination Committee, the test plan document is presented for approval to the Delegate Assembly, which is the decision-making body of NCSBN.

About the NCLEX-RN® Detailed Test Plan (Section III)

The detailed test plan serves a variety of purposes. It is used to guide candidates preparing for the examination, to direct item writers in the development of items, and to facilitate the classification of examination items. Two versions of the detailed test plan have been created:

Item Writer/Item Reviewer/Nurse Educator version and Candidate version. The Candidate version that is provided in this document offers a more thorough and comprehensive listing of content for each client needs category and subcategory outlined in the test plan. Sample items are provided at the end of each category, which are specific to the client needs category being reviewed in that section. The Candidate version of the detailed test plan provides the same comprehensive listing of content and sample items for each client needs category and subcategory outlined in the test plan, however, it does not offer an item writing guide or section with case scenarios.

For up-to-date information about the NCLEX-RN examination, visit the NCSBN website at www.ncsbn.org.

II. *2016 NCLEX-RN® Test Plan*

Test Plan for the National Council Licensure Examination for Registered Nurses (NCLEX-RN® Examination)

Introduction

Entry into the practice of nursing is regulated by the licensing authorities within each of the National Council of State Boards of Nursing (NCSBN®) member board jurisdictions (state, province, commonwealth, and territorial boards of nursing). To ensure public protection, each jurisdiction requires candidates for licensure to meet set requirements that include passing an examination that measures the competencies needed to perform safely and effectively as a newly licensed, entry-level registered nurse. NCSBN develops a licensure examination, the National Council Licensure Examination for Registered Nurses (NCLEX-RN®), which is used by member board jurisdictions to assist in making licensure decisions.

Several steps occur in the development of the NCLEX-RN Test Plan. The first step is conducting a practice analysis that is used to collect data on the current practice of the entry-level nurse (*Report of Findings from the 2014 RN Practice Analysis: Linking the NCLEX-RN® Examination to Practice*, NCSBN, 2015). Twelve thousand newly licensed registered nurses are asked about the frequency and importance of performing nursing care activities. Nursing care activities are then analyzed in relation to the frequency of performance, impact on maintaining client safety, and client care settings where the activities are performed. This analysis guides the development of a framework for entry-level nursing practice that incorporates specific client needs as well as processes fundamental to the practice of nursing. The second step is the development of the NCLEX-RN Test Plan, which guides the selection of content and behaviors to be tested.

The NCLEX-RN Test Plan provides a concise summary of the content and scope of the licensure examination. It serves as a guide for examination development as well as candidate preparation. The NCLEX assesses the knowledge, skills and abilities that are essential for the entry-level nurse to use in order to meet the needs of clients requiring the promotion, maintenance or restoration of health. The following sections describe beliefs about people and nursing that are integral to the examination, cognitive abilities that will be tested in the examination and specific components of the NCLEX-RN Test Plan.

Beliefs

Beliefs about people and nursing underlie the NCLEX-RN Test Plan. People are finite beings with varying capacities to function in society. They are unique individuals who have defined systems of daily living reflecting their values, motives and lifestyles. People have the right to make decisions regarding their health care needs and to participate in meeting those needs. The profession of nursing makes a unique contribution in helping clients (individual, family or group, including significant others and population) achieve an optimal level of health in a variety of settings. For the purposes of the NCLEX, a client is defined as the individual, family, or group which includes significant others and population.

Nursing is both an art and a science, founded on a professional body of knowledge that integrates concepts from the liberal arts and the biological, physical, psychological and social sciences. It is a learned profession based on knowledge of the human condition across the life span and the relationships of an individual with others and within the environment. Nursing is a dynamic, continually evolving discipline that employs critical thinking to

integrate increasingly complex knowledge, skills, technologies, and client care activities into evidence-based nursing practice. The goal of nursing for client care is preventing illness and potential complications; protecting, promoting, restoring, and facilitating comfort; health; and dignity in dying.

The registered nurse provides a unique, comprehensive assessment of the health status of the client, applying principles of ethics, client safety, health promotion and the nursing process, the nurse then develops and implements an explicit plan of care considering unique cultural and spiritual client preferences, the applicable standard of care and legal instructions. The nurse assists clients to promote health, cope with health problems, adapt to and/or recover from the effects of disease or injury, and support the right to a dignified death. The registered nurse is accountable for abiding by all applicable member board jurisdiction statutes related to nursing practice.

Classification of Cognitive Levels

Bloom's taxonomy for the cognitive domain is used as a basis for writing and coding items for the examination (Bloom, et al., 1956; Anderson & Krathwohl, 2001). Since the practice of nursing requires application of knowledge, skills and abilities, the majority of items are written at the application or higher levels of cognitive ability, which requires more complex thought processing.

Test Plan Structure

The framework of Client Needs was selected for the examination because it provides a universal structure for defining nursing actions and competencies, and focuses on clients in all settings.

Client Needs

The content of the NCLEX-RN Test Plan is organized into four major Client Needs categories. Two of the four categories are divided into subcategories:

Safe and Effective Care Environment

- Management of Care
- Safety and Infection Control

Health Promotion and Maintenance

Psychosocial Integrity

Physiological Integrity

- Basic Care and Comfort
- Pharmacological and Parenteral Therapies
- Reduction of Risk Potential
- Physiological Adaptation

Integrated Processes

The following processes are fundamental to the practice of nursing and are integrated throughout the Client Needs categories and subcategories:

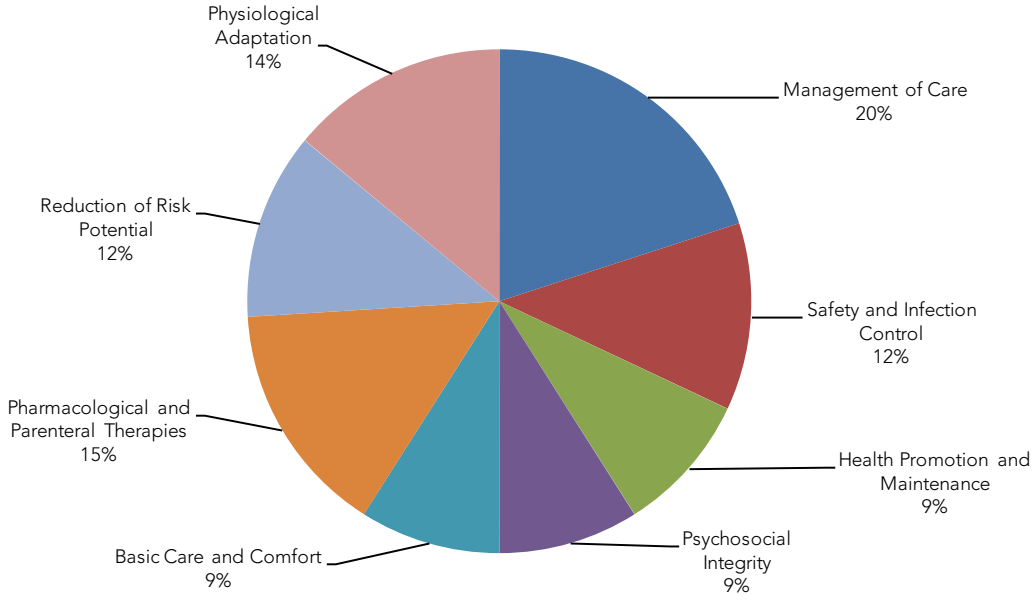
- *Nursing Process* – a scientific, clinical reasoning approach to client care that includes assessment, analysis, planning, implementation and evaluation.
- *Caring* – interaction of the nurse and client in an atmosphere of mutual respect and trust. In this collaborative environment, the nurse provides encouragement, hope, support and compassion to help achieve desired outcomes.
- *Communication and Documentation* – verbal and nonverbal interactions between the nurse and the client, the client's significant others, and the other members of the health care team. Events and activities associated with client care are recorded in written and/or electronic records that demonstrate adherence to the standards of practice and accountability in the provision of care.
- *Teaching/Learning* – facilitation of the acquisition of knowledge, skills and attitudes promoting a change in behavior.
- *Culture and Spirituality* – interaction of the nurse and the client (individual, family or group, including significant others and population) which recognizes and considers the client-reported, self-identified, unique and individual preferences to client care, the applicable standard of care and legal instructions.

Distribution of Content

The percentage of test questions assigned to each Client Needs category and subcategory of the NCLEX-RN Test Plan is based on the results of the *Report of Findings from the 2014 RN Practice Analysis: Linking the NCLEX-RN® Examination to Practice* (NCSBN, 2015) and expert judgment provided by members of the NCLEX® Examination Committee.

Client Needs	Percentage of Items from Each Category/Subcategory
Safe and Effective Care Environment	
▪ Management of Care	17-23%
▪ Safety and Infection Control	9-15%
Health Promotion and Maintenance	6-12%
Psychosocial Integrity	6-12%
Physiological Integrity	
▪ Basic Care and Comfort	6-12%
▪ Pharmacological and Parenteral Therapies	12-18%
▪ Reduction of Risk Potential	9-15%
▪ Physiological Adaptation	11-17%

Distribution of Content for the NCLEX-RN® Test Plan



NCLEX-RN examinations are administrated adaptively in variable length format to target candidate-specific ability. To accommodate possible variations in test length, content area distributions of the individual examinations may differ up to ±3% in each category.

Overview of Content

All content categories and subcategories reflect client needs across the life span in a variety of settings.

Safe and Effective Care Environment

The nurse promotes achievement of client outcomes by providing and directing nursing care that enhances the care delivery setting in order to protect clients and health care personnel.

- *Management of Care* – providing and directing nursing care that enhances the care delivery setting to protect clients and health care personnel.

  Related content includes, but is **not limited** to:

  - Advance Directives/Self-Determination/ Life Planning
  - Advocacy
  - Assignment, Delegation and Supervision
  - Case Management
  - Client Rights
  - Collaboration with Interdisciplinary Team
  - Concepts of Management
  - Confidentiality/Information Security
  - Continuity of Care
  - Establishing Priorities
  - Ethical Practice
  - Informed Consent
  - Information Technology
  - Legal Rights and Responsibilities
  - Organ Donation
  - Performance Improvement (Quality Improvement)
  - Referrals

- *Safety and Infection Control* – protecting clients and health care personnel from health and environmental hazards.

  Related content includes, but is **not limited** to:

  - Accident/Error/Injury Prevention
  - Emergency Response Plan
  - Ergonomic Principles
  - Handling Hazardous and Infectious Materials
  - Home Safety
  - Reporting of Incident/Event/Irregular Occurrence/Variance
  - Safe Use of Equipment
  - Security Plan
  - Standard Precautions/Transmission-Based Precautions/Surgical Asepsis
  - Use of Restraints/Safety Devices

Health Promotion and Maintenance

The nurse provides and directs nursing care of the client that incorporates the knowledge of expected growth and development principles, prevention and/or early detection of health problems, and strategies to achieve optimal health.

Related content includes, but is **not limited** to:

- Aging Process
- Ante/Intra/Postpartum and Newborn Care
- Developmental Stages and Transitions
- Health Promotion/Disease Prevention
- Health Screening
- High Risk Behaviors
- Lifestyle Choices
- Self-Care
- Techniques of Physical Assessment

Psychosocial Integrity

The nurse provides and directs nursing care that promotes and supports the emotional, mental and social well-being of the client experiencing stressful events, as well as clients with acute or chronic mental illness.

Related content includes, but is **not limited** to:

- Abuse/Neglect
- Behavioral Interventions
- Chemical and Other Dependencies/ Substance Use Disorder
- Coping Mechanisms
- Crisis Intervention
- Cultural Awareness/Cultural Influences on Health
- End of Life Care
- Family Dynamics
- Grief and Loss
- Mental Health Concepts
- Religious and Spiritual Influences on Health
- Sensory/Perceptual Alterations
- Stress Management
- Support Systems
- Therapeutic Communication
- Therapeutic Environment

Physiological Integrity

The nurse promotes physical health and wellness by providing care and comfort, reducing client risk potential and managing health alterations.

- *Basic Care and Comfort* - providing comfort and assistance in the performance of activities of daily living.

  Related content includes, but is **not limited** to:

  - Assistive Devices
  - Elimination
  - Mobility/Immobility
  - Non-Pharmacological Comfort Interventions
  - Nutrition and Oral Hydration
  - Personal Hygiene
  - Rest and Sleep

- *Pharmacological and Parenteral Therapies* - providing care related to the administration of medications and parenteral therapies.

  Related content includes, but is **not limited** to:

  - Adverse Effects/Contraindications/Side Effects/Interactions
  - Blood and Blood Products
  - Central Venous Access Devices
  - Dosage Calculation
  - Expected Actions/Outcomes
  - Medication Administration
  - Parenteral/Intravenous Therapies
  - Pharmacological Pain Management
  - Total Parenteral Nutrition

- *Reduction of Risk Potential* - reducing the likelihood that clients will develop complications or health problems related to existing conditions, treatments or procedures.

  Related content includes, but is **not limited** to:

  - Changes/Abnormalities in Vital Signs
  - Diagnostic Tests
  - Laboratory Values
  - Potential for Alterations in Body Systems
  - Potential for Complications of Diagnostic Tests/Treatments/Procedures
  - Potential for Complications from Surgical Procedures and Health Alterations
  - System Specific Assessments
  - Therapeutic Procedures

- *Physiological Adaptation* - managing and providing care for clients with acute, chronic or life threatening physical health conditions.

  Related content includes, but is **not limited** to:

  - Alterations in Body Systems
  - Fluid and Electrolyte Imbalances
  - Hemodynamics
  - Illness Management
  - Medical Emergencies
  - Pathophysiology
  - Unexpected Response to Therapies

III. *2016 NCLEX-RN® Detailed Test Plan*

Detailed Test Plan for the National Council Licensure Examination for Registered Nurses (NCLEX-RN® Examination)

The NCLEX-RN Test Plan in the previous section provides a general outline of the categories and subcategories of the examination. The *2016 NCLEX-RN® Detailed Test Plan* (Candidate Version) is used to guide the direction of examination content to be followed by NCLEX® candidates preparing to take the examination

The activity statements used in the *2014 RN Practice Analysis: Linking the NCLEX-RN® Examination to Practice* (NCSBN, 2015) preface each of the eight content categories and are identified throughout the detailed test plan by an asterisk(*). NCSBN performs an analysis of those activities used frequently and identified as important by entry-level nurses to ensure client safety. This is called a practice analysis; it provides data to support the NCLEX as a reliable, valid measure of competent, entry-level nursing practice. The practice analysis is conducted at least every three years.

In addition to the practice analysis performed every three years, NCSBN conducts a knowledge, skills and abilities (KSA) survey. The primary purpose of this study is to identify the knowledge needed by newly licensed registered nurses (RNs) in order to practice safe and effective care. Findings from both the 2014 RN Practice Analysis and the 2014 RN KSA survey can be found at www.ncsbn.org/1235.htm. Both documents are used in the development of the NCLEX-RN Test Plan as well as to inform item development.

All task statements in the *2016 NCLEX-RN® Detailed Test Plan* require the nurse to apply the fundamental principles of clinical decision making and critical thinking to nursing practice. The detailed test plan also makes the assumption that the nurse integrates concepts from the following bodies of knowledge::

- Social sciences (psychology and sociology);
- Biological sciences (anatomy, physiology, biology and microbiology); and
- Physical sciences (chemistry and physics).

In addition, the following concepts are utilized throughout the four major Client Needs categories and subcategories of the test plan:

- Nursing process;
- Caring;
- Communication and documentation;
- Teaching and learning; and
- Culture and Spirituality.

Please Note: There are certain inconsistencies throughout this document related to word usage and punctuation. Sentences or phrases marked by an asterisk (*) are activity statements taken directly from the *2014 RN Practice Analysis: Linking the NCLEX-RN® Examination to Practice*. In order to provide proper attribution to the original survey these statements have not been altered to fit the overall grammatical style of this document. In addition, the term "client" refers to the individual, family, or group, which includes significant others and population. "Clients" are the same as "residents" or "patients." In general, if the age or age category of the client is not stated in an item, it can be understood that the client is an adult. NCLEX items are developed based on a variety of practice settings such as: acute/critical care, long-term care/rehabilitation care, outpatient care and community-based/home care settings.

Safe and Effective Care Environment

Management of Care

- **Management of Care** – the nurse provides and directs nursing care that enhances the care delivery setting to protect the client and health care personnel.

MANAGEMENT OF CARE **Related Activity Statements from the *2014 RN Practice Analysis: Linking the NCLEX-RN® Examination to Practice***
▪ Integrate advance directives into client plan of care ▪ Assign and supervise care provided by others (e.g., LPN/VN, assistive personnel, other RNs) ▪ Organize workload to manage time effectively ▪ Participate in providing cost effective care ▪ Initiate, evaluate, and update plan of care (e.g., care map, clinical pathway) ▪ Provide education to clients and staff about client rights and responsibilities ▪ Advocate for client rights and needs ▪ Collaborate with interprofessional health care members in other disciplines when providing client care (e.g., language interpreter, health care professionals) ▪ Manage conflict among clients and health care staff ▪ Maintain client confidentiality and privacy ▪ Provide and receive hand off of care report on assigned clients (e.g., standardized hand off communication) ▪ Use approved abbreviations and standard terminology when documenting care ▪ Perform procedures necessary to safely admit, transfer or discharge a client ▪ Prioritize the delivery of client care ▪ Recognize ethical dilemmas and take appropriate action ▪ Practice in a manner consistent with a code of ethics for registered nurses ▪ Verify that the client received appropriate procedure education and consents to care and procedures ▪ Receive and/or transcribe health care provider orders ▪ Utilize valid resources to enhance the care provided to a client (e.g., evidenced-based research, information technology, policies and procedures) ▪ Recognize limitations of self/others and seek assistance ▪ Report client conditions as required by law (e.g., abuse/neglect, communicable disease) ▪ Report unsafe practice of health care personnel and intervene as appropriate (e.g., substance abuse, improper care, staffing practices) ▪ Provide care within the legal scope of practice ▪ Participate in performance improvement/quality improvement process ▪ Recognize the need for referrals and obtain necessary orders

Related content includes, but is **not limited** to:

Advance Directives

- Assess client and/or staff member knowledge of advance directives (e.g., living will, health care agent/proxy, Power of Attorney for Health Care)
- Integrate advance directives into client plan of care*
- Provide client with information about advance directives, self-care determination, life planning.

Advocacy

- Discuss identified treatment options with client and respect their decisions
- Provide information on advocacy to staff members
- Act in the role of client advocate
- Utilize advocacy resources appropriately (e.g., social worker, chain of command, interpreter)

Assignment, Delegation and Supervision

- Identify tasks for assignment or delegation based on client needs
- Delegate and assign appropriate task based on client's needs to personnel with competency to perform task
- Assign and supervise care provided by others (e.g., LPN/VN, assistive personnel, other RNs)*
- Communicate tasks to be completed and report client concerns immediately
- Organize workload to manage time effectively*
- Utilize the rights of delegation (e.g., right task, right circumstances, right person, right direction or communication, right supervision or feedback)
- Evaluate delegated tasks to ensure correct completion of activity
- Evaluate ability of staff members to perform assigned tasks considering personnel's allowable tasks/duties, competency and ability to use sound judgment and decision making.
- Evaluate effectiveness of staff members' time management skills

Case Management

- Explore resources available to assist the client with achieving or maintaining independence
- Assess the client's need for materials and equipment (e.g., oxygen, suction machine, wound care supplies)
- Provide cost effective care*(not including payor or insurance)
- Plan individualized care for client based on need (e.g., client diagnosis, self-care ability, prescribed treatments)
- Provide client with information on discharge procedures to home, or community setting
- Initiate, evaluate, and update plan of care (e.g., care map, clinical pathway)*

*Activity Statements used in the 2014 RN Practice Analysis

Client Rights

- Recognize the client's right to refuse treatment/procedures
- Discuss treatment options/decisions with client
- Provide education to clients and staff about client rights and responsibilities*
- Evaluate client/staff understanding of client rights
- Advocate for client rights and needs*

Collaboration with Interdisciplinary Team

- Identify the need for interdisciplinary conferences
- Identify significant information to report to other disciplines (e.g., health care provider, pharmacist, social worker, respiratory therapist)
- Review plan of care to ensure continuity across disciplines
- Collaborate with interprofessional members when providing client care*
- Serve as resource person to other staff

Concepts of Management

- Identify roles/responsibilities of health care team members
- Plan overall strategies to address client problems
- Act as liaison between client and others (e.g., coordinate care, manage care)
- Manage conflict among clients and health care staff*
- Evaluate management outcomes

Confidentiality/Information Security

- Assess staff member and client understanding of confidentiality requirements
- Maintain client confidentiality and privacy*
- Intervene appropriately when confidentiality has been breached by staff members

Continuity of Care

- Provide and receive hand off of care report on assigned clients (e.g., standardized hand off communication)*
- Use documents to record and communicate client information (e.g., medical record, referral/transfer form)
- Use approved abbreviations and standard terminology when documenting care*
- Perform procedures necessary to safely admit, transfer or discharge a client*
- Follow up on unresolved issues regarding client care (e.g., laboratory results, client requests)

Establishing Priorities

- Apply knowledge of pathophysiology when establishing priorities for interventions with multiple clients
- Prioritize the delivery of client care*
- Evaluate plan of care for multiple clients and revise plan of care as needed

*Activity Statements used in the 2014 RN Practice Analysis

Ethical Practice

- Recognize ethical dilemmas and take appropriate action*
- Inform client/staff members of ethical issues affecting client care
- Practice in a manner consistent with a code of ethics for registered nurses*
- Evaluate outcomes of interventions to promote ethical practice

Informed Consent

- Identify appropriate person to provide informed consent for client
- Provide written materials in client's spoken language, when possible
- Describe components of informed consent
- Participate in obtaining informed consent
- Verify that the client received appropriate procedure education and consents to care and procedures*

Information Technology

- Receive and/or transcribe health care provider orders* (orders/prescriptions)
- Apply knowledge of facility regulations when accessing client records
- Access data for client through online databases and journals
- Enter computer documentation accurately, completely and in a timely manner
- Utilize valid resources to enhance the care provided to a client (e.g., evidenced-based research, information technology, policies and procedures)*

Legal Rights and Responsibilities

- Identify legal issues affecting the client (e.g., refusing treatment)
- Identify and manage the client's valuables according to facility/agency policy
- Recognize limitations of self/others and seek assistance*
- Review facility policy and legal considerations prior to agreeing to serve as an interpreter for staff or primary health care provider
- Educate client/staff on legal issues
- Report client conditions as required by law (e.g., abuse/neglect, communicable disease)*
- Report unsafe practice of health care personnel and intervene as appropriate (e.g., substance abuse, improper care, staffing practices)*
- Provide care within the legal scope of practice*

*Activity Statements used in the 2014 RN Practice Analysis

Performance Improvement (Quality Improvement)

- Define performance improvement/quality assurance activities
- Participate in performance improvement/quality improvement process*
- Report identified client care issues/problems to appropriate personnel
- Utilize research and other references for performance improvement actions
- Evaluate the impact of performance improvement measures on client care and resource utilization

Referrals

- Assess the need to refer clients for assistance with actual or potential problems (e.g., physical therapy, speech therapy)
- Recognize the need for referrals and obtain necessary orders* (orders/prescriptions)
- Identify community resources for the client (e.g., respite care, social services, shelters)
- Identify which documents to include when referring a client (e.g., medical record, referral form)

Sample Item
The nurse is caring for a client in a long term care facility. The client's neighbor asks the nurse for information regarding the client's treatment plan. Which of the following responses would be **most** appropriate for the nurse to make? 1. "I cannot give you information on the client without the client's consent." **(key)** 2. "Can you verify the client's date of birth?" 3. "Let me contact the admission department to speak with you." 4. "I will share the client's treatment plan with you after breakfast."

(Key) is used throughout this document to denote the correct answer(s) for the exam item.

*Activity Statements used in the 2014 RN Practice Analysis

Safety and Infection Control

- Safety and Infection Control – The nurse protects clients and health care personnel from health and environmental hazards.

SAFETY AND INFECTION CONTROL **Related Activity Statements from the *2014 RN Practice Analysis: Linking the NCLEX-RN Examination to Practice***
▪ Assess client for allergies and intervene as needed (e.g., food, latex, environmental allergies) ▪ Protect client from injury (e.g., falls, electrical hazards) ▪ Ensure proper identification of client when providing care ▪ Verify appropriateness and/or accuracy of a treatment order ▪ Implement emergency response plans (e.g., internal/external disaster) ▪ Use ergonomic principles when providing care (e.g., safe patient handling, proper lifting) ▪ Follow procedures for handling biohazardous materials ▪ Educate client on home safety issues (e.g., home, school, transportation) ▪ Acknowledge and document practice error (e.g., incident report for medication error) ▪ Facilitate appropriate and safe use of equipment ▪ Follow security plan and procedures (e.g., newborn nursery security, violence, controlled access) ▪ Apply principles of infection control (e.g., hand hygiene, surgical asepsis, isolation, sterile technique, universal/standard precautions) ▪ Educate client and staff regarding infection control measures ▪ Follow requirements regarding for use of restraints and/or safety device (e.g., least restrictive restraints, timed client monitoring)

Related content includes, but is **not limited** to:

Accident/Error/Injury Prevention

- Assess client for allergies and intervene as needed (e.g., food, latex, environmental allergies)*
- Determine client/staff member knowledge of safety procedures
- Identify factors that influence accident/injury prevention (e.g., age, developmental stage, lifestyle, mental status)
- Identify deficits that may impede client safety (e.g., visual, hearing, sensory/perceptual)
- Identify and verify prescriptions for treatments that may contribute to an accident or injury (does not include medication)
- Identify and facilitate correct use of infant and child car seats
- Provide client with appropriate method to signal staff members
- Protect client from injury (e.g., falls, electrical hazards)*
- Review necessary modifications with client to reduce stress on specific muscle or skeletal groups

*Activity Statements used in the 2014 RN Practice Analysis

(e.g., frequent changing of position, routine stretching of the shoulders, neck, arms, hands, fingers)

- Implement seizure precautions for at-risk clients
- Make appropriate room assignments for cognitively impaired clients
- Ensure proper identification of client when providing care*
- Verify appropriateness and/or accuracy of a treatment order*

Emergency Response Plan

- Determine which client(s) to recommend for discharge in a disaster situation
- Identify nursing roles in disaster planning
- Use clinical decision-making/critical thinking for emergency response plan
- Implement emergency response plans (e.g., internal/external disaster)*
- Participate in disaster planning activities/drills

Ergonomic Principles

- Assess client ability to balance, transfer and use assistive devices prior to planning care (e.g., crutches, walker)
- Provide instruction and information to client about body positions that eliminate potential for repetitive stress injuries
- Use ergonomic principles when providing care (e.g., safe client handling, proper lifting)*

Handling Hazardous and Infectious Materials

- Identify biohazardous, flammable and infectious materials
- Follow procedures for handling biohazardous materials*
- Demonstrate safe handling techniques to staff and client
- Ensure safe implementation of internal radiation therapy

Home Safety

- Assess need for client home modifications (e.g., lighting, handrails, kitchen safety)
- Apply knowledge of client pathophysiology to home safety interventions
- Educate client on home safety issues (e.g., home, school, transportation)*
- Encourage the client to use protective equipment when using devices that can cause injury Evaluate client care environment for fire/environmental hazard

Reporting of Incident/Event/Irregular Occurrence/Variance

- Identify need/situation where reporting of incident/event/irregular occurrence/variance is appropriate
- Acknowledge and document practice error (e.g., incident report for medication error)*
- Evaluate response to error/event/occurrence

*Activity Statements used in the 2014 RN Practice Analysis

Safe Use of Equipment

- Inspect equipment for safety hazards (e.g., frayed electrical cords, loose/missing parts)
- Teach client about the safe use of equipment needed for health care
- Facilitate appropriate and safe use of equipment*
- Remove malfunctioning equipment from client care area and report the problem to appropriate personnel

Security Plan

- Use clinical decision making/critical thinking in situations related to security planning
- Apply principles of triage and evacuation procedures/protocols
- Follow security plan and procedures (e.g., newborn nursery security, violence, controlled access)*

Standard Precautions/Transmission-Based Precautions/Surgical Asepsis

- Assess client care area for sources of infection
- Understand communicable diseases and the modes of organism transmission (e.g., airborne, droplet, contact)
- Apply principles of infection control (e.g., hand hygiene, surgical asepsis, isolation, sterile technique, universal/standard precautions)*
- Follow correct policy and procedures when reporting a client with a communicable disease
- Educate client and staff regarding infection control measures*
- Utilize appropriate precautions for immunocompromised clients
- Use appropriate technique to set up a sterile field/maintain asepsis (e.g., gloves, mask, sterile supplies)
- Evaluate infection control precautions implemented by staff members
- Evaluate whether aseptic technique is performed correctly

Use of Restraints/Safety Devices

- Assess appropriateness of the type of restraint/safety device used
- Follow requirements for use of restraints and/or safety device (e.g., least restrictive restraints, timed client monitoring)*
- Monitor/evaluate client response to restraints/safety device

Sample Item
The nurse is caring for a client who has streptococcal pneumonia. Which of the following infection control precautions should the nurse implement? 1. Request the dietary department provide disposable utensils on the client's meal tray. 2. Wear a surgical mask when obtaining the client's vital signs. **(key)** 3. Remove fresh flowers from the client's room. 4. Place the client in a private room with monitored negative air pressure.

*Activity Statements used in the 2014 RN Practice Analysis

Health Promotion and Maintenance

- **Health Promotion and Maintenance** – the nurse provides and directs nursing care of the client that incorporates knowledge of expected growth and development principles; prevention and/or early detection of health problems; and strategies to achieve optimal health.

HEALTH PROMOTION AND MAINTENANCE **Related Activity Statements from the *2014 RN Practice Analysis: Linking the NCLEX-RN Examination to Practice***
▪ Provide care and education for the newborn less than 1 month old through the infant or toddler client through 2 years ▪ Provide care and education for the preschool, school age and adolescent client ages 3 through 17 years ▪ Provide care and education for the adult client ages 18 through 64 years ▪ Provide care and education for the adult client ages 65 through 85 years and over ▪ Provide prenatal care and education ▪ Provide care to client in labor or antepartum client ▪ Provide post-partum care and education ▪ Assess and teach clients about health risks based on family, population, and/or community characteristics ▪ Assess client's readiness to learn, learning preferences and barriers to learning ▪ Plan and/or participate in community health education ▪ Provide information about health promotion and maintenance recommendations (e.g., physician visits, immunizations) ▪ Perform targeted screening assessments (e.g., vision, nutrition) ▪ Provide information for prevention and treatment of high risk health behaviors (e.g., smoking cessation, safe sexual practices, needle exchange) ▪ Assess client ability to manage care in home environment and plan care accordingly (e.g., equipment, community resources) ▪ Perform comprehensive health assessment

Related content includes, but is **not limited** to:

Aging Process

- Assess client's reactions to expected age-related changes
- Provide care and education for the newborn less than 1 month old through the infant or toddler client through 2 years*
- Provide care and education for the preschool, school age and adolescent client ages 3 through 17 years*
- Provide care and education for the adult client ages 18 through 64 years*
- Provide care and education for the adult client ages 65 through 85 years and over*

*Activity Statements used in the 2014 RN Practice Analysis

Ante/Intra/Postpartum and Newborn Care

- Assess client's psychosocial response to pregnancy (e.g., support systems, perception of pregnancy, coping mechanisms)
- Assess client for symptoms of postpartum complications (e.g., hemorrhage, infection)
- Recognize cultural differences in childbearing practices
- Calculate expected delivery date
- Check fetal heart rate during routine prenatal exams
- Assist client with performing/learning newborn care (e.g., feeding)
- Provide prenatal care and education*
- Provide care and education to client in labor or an antepartum client*
- Provide post-partum care and education*
- Provide discharge instructions (e.g., post-partum and newborn care)
- Evaluate client's ability to care for the newborn

Developmental Stages and Transitions

- Identify expected physical, cognitive and psychosocial stages of development
- Identify expected body image changes associated with client developmental age (e.g., aging, pregnancy)
- Identify family structures and roles of family members (e.g., nuclear, blended, adoptive)
- Compare client development to expected age/developmental stage and report any deviations
- Assess impact of change on family system (e.g., one-parent family, divorce, ill family member)
- Recognize cultural and religious influences that may impact family functioning
- Assist client to cope with life transitions (e.g., attachment to newborn, parenting, puberty, retirement)
- Modify approaches to care in accordance with client developmental stage (use age appropriate explanations of procedures and treatments)
- Provide education to client/staff members about expected age-related changes and age-specific growth and development (e.g., developmental stages)
- Evaluate client's achievement of expected developmental level (e.g., developmental milestones)
- Evaluate impact of expected body image changes on client and family

Health Promotion/Disease Prevention

- Identify risk factors for disease/illness (e.g., age, gender, ethnicity, lifestyle)
- Assess and teach clients about health risks based on family, population, and/or community characteristics*
- Assess client's readiness to learn, learning preferences and barriers to learning*
- Plan and/or participate in community health education*
- Educate the client on actions to promote/maintain health and prevent disease (e.g., smoking cessation, diet, weight loss)
- Inform the client of appropriate immunization schedules
- Integrate complementary therapies into health promotion activities for the well client

*Activity Statements used in the 2014 RN Practice Analysis

- Provide information about health promotion and maintenance recommendations (e.g., physician visits, immunizations)*
- Provide follow-up to the client following participation in health promotion program (e.g., diet counseling)
- Assist the client in maintaining an optimum level of health
- Evaluate client understanding of health promotion behaviors/activities (e.g., weight control, exercise actions)

Health Screening

- Apply knowledge of pathophysiology to health screening
- Identify risk factors linked to ethnicity (e.g., hypertension, diabetes)
- Perform health history/health and risk assessments (e.g., lifestyle, family and genetic history)
- Perform targeted screening assessments (e.g., vision, , nutrition)*
- Utilize appropriate procedure and interviewing techniques when taking the client health history

High Risk Behaviors

- Assess client lifestyle practice risks that may impact health (e.g., excessive sun exposure, lack of regular exercise)
- Assist the client to identify behaviors/risks that may impact health
- Provide information for prevention and treatment of high risk health behaviors (e.g., smoking cessation, safe sexual practices, needle exchange)*

Lifestyle Choices

- Assess the client's lifestyle choices
- Assess client's attitudes/perceptions on sexuality
- Assess client's need/desire for contraception
- Identify contraindications to chosen contraceptive method (e.g., smoking, compliance, medical conditions)
- Identify expected outcomes for family planning methods
- Recognize client who is socially or environmentally isolated
- Educate the client on sexuality issues (e.g., family planning, safe sexual practices, menopause, impotence)
- Evaluate client alternative or homeopathic health care practices (e.g., massage therapy, acupuncture, herbal medicine and minerals)

Self Care

- Assess client ability to manage care in home environment and plan care accordingly (e.g., equipment, community resources)*
- Consider client self care needs before developing or revising care plan
- Assist primary caregivers working with the client to meet self-care goals

*Activity Statements used in the 2014 RN Practice Analysis

Techniques of Physical Assessment

- Apply knowledge of nursing procedures and psychomotor skills to techniques of physical assessment
- Choose physical assessment equipment and technique appropriate for the client (e.g., age of client, measurement of vital signs)
- Perform comprehensive health assessment*

Sample Item
The nurse is teaching a client about contraception. Which of the following information should the nurse include? 1. "Emergency contraception is most effective if used within 72 hours of unprotected intercourse." **(key)** 2. "If used correctly, a birth control patch will protect you from contracting a sexually transmitted disease (STD)." 3. "If you use an intrauterine device for contraception, it will need to be replaced every month." 4. "You cannot use medroxyprogesterone if you smoke cigarettes."

*Activity Statements used in the 2014 RN Practice Analysis

Psychosocial Integrity

- **Psychosocial Integrity** – the nurse provides and directs nursing care that promotes and supports the emotional, mental and social well being of the client experiencing stressful events, as well as clients with acute or chronic mental illness.

PSYCHOSOCIAL INTEGRITY **Related Activity Statements from the *2014 RN Practice Analysis: Linking the NCLEX-RN Examination to Practice***
▪ Assess client for abuse or neglect and intervene as appropriate ▪ Incorporate behavioral management techniques when caring for a client (e.g., positive reinforcement, setting limits, de-escalation techniques) ▪ Assess client for drug/alcohol dependencies, withdrawal, or toxicities and intervene as appropriate ▪ Assess client in coping with life changes and provide support (e.g., palliative, amputation, new diagnosis) ▪ Assess the potential for violence and use safety precautions (e.g., suicide, homicide, self-destructive behavior) ▪ Incorporate client cultural practice and beliefs when planning and providing care ▪ Provide end of life care and education to clients ▪ Assess family dynamics to determine plan of care (e.g., structure, bonding, communication, boundaries, coping mechanisms) ▪ Provide care and education for acute and chronic psychosocial health issues (e.g., addictions/dependencies , depression, dementia, eating disorders) ▪ Assess psychosocial, spiritual and occupational factors affecting care, and plan interventions ▪ Provide care for a client experiencing visual, auditory or cognitive distortions (e.g., hallucinations) ▪ Recognize non-verbal cues to physical and/or psychological stressors ▪ Use therapeutic communication techniques to provide client support ▪ Provide a therapeutic environment for clients

Related content includes, but is **not limited** to:

Abuse/Neglect

- Assess client for abuse or neglect and intervene as appropriate*
- Identify risk factors for domestic, child, elder abuse/neglect and sexual abuse
- Plan interventions for victims/suspected victims of abuse
- Counsel victims/suspected victims of abuse and their families on coping strategies
- Provide a safe environment for the abused/neglected client
- Evaluate client response to interventions

*Activity Statements used in the 2014 RN Practice Analysis

Behavioral Interventions

- Assess the client's appearance, mood and psychomotor behavior and identify/respond to inappropriate/abnormal behavior
- Assist the client with achieving and maintaining self-control of behavior (e.g., behavior modification)
- Assist the client to develop and use strategies to decrease anxiety
- Orient the client to reality
- Participate in group sessions (e.g., support groups)
- Incorporate behavioral management techniques when caring for a client (e.g., positive reinforcement, setting limits, de-escalation techniques)*
- Evaluate the client's response to treatment plan

Chemical and Other Dependencies/Substance Use Disorder

- Assess the client's reactions to the diagnosis/treatment of substance-related disorder
- Assess client for drug/alcohol dependencies, withdrawal, or toxicities and intervene as appropriate*
- Plan and provide care to clients experiencing substance-related withdrawal or toxicity (e.g., nicotine, opioid, sedative)
- Provide information on substance abuse diagnosis and treatment plan to the client
- Provide care and/or support for a client with non-substance-related dependencies (e.g., gambling, sexual addiction)
- Provide symptom management for clients experiencing withdrawal or toxicity
- Encourage client to participate in support groups
- Evaluate the client's response to a treatment plan and revise as needed

Coping Mechanisms

- Assess the client's support systems and available resources
- Assess the client's ability to adapt to temporary/permanent role changes
- Assess the client's reaction to a diagnosis of acute or chronic mental illness (e.g., rationalization, hopefulness, anger)
- Assess client in coping with life changes and provide support (e.g., palliative care, amputation, new diagnosis)*
- Identify situations which may necessitate role changes for a client (e.g., spouse with chronic illness, death of parent)
- Provide support to the client with unexpected altered body image (e.g., alopecia)
- Evaluate the constructive use of defense mechanisms by a client
- Evaluate whether the client has successfully adapted to situational role changes (e.g., accept dependency on others)

*Activity Statements used in the 2014 RN Practice Analysis

Crisis Intervention

- Assess the potential for violence and use safety precautions (e.g., suicide, homicide, self-destructive behavior)*
- Identify the client in crisis
- Use crisis intervention techniques to assist the client in coping
- Apply knowledge of client psychopathology to crisis intervention
- Guide the client to resources for recovery from crisis (e.g., social supports)

Cultural Awareness/Cultural Influences on Health

- Assess the importance of client culture/ethnicity when planning/providing/evaluating care
- Recognize cultural issues that may impact the client's understanding/acceptance of psychiatric diagnosis
- Incorporate client cultural practice and beliefs when planning and providing care*
- Respect cultural background/practices of the client (does not include dietary preferences)
- Evaluate and document how client language needs were met

End of Life Care

- Assess the client's ability to cope with end of life interventions
- Identify end of life needs of the client (e.g., financial concerns, fear, loss of control, role changes)
- Recognize the need for and provide psychosocial support to the family/caregiver
- Assist the client in resolution of end of life issues
- Provide end of life care and education to clients*

Family Dynamics

- Assess barriers/stressors that impact family functioning (e.g., meeting client care needs, divorce)
- Assess family dynamics to determine plan of care (e.g., structure, bonding, communication, boundaries, coping mechanisms)*
- Assess parental techniques related to discipline
- Encourage the client's participation in group/family therapy
- Assist the client to integrate new members into family structure (e.g., new infant, blended family)
- Evaluate resources available to assist family functioning

Grief and Loss

- Assist the client in coping with suffering, grief, loss, dying, and bereavement
- Support the client in anticipatory grieving
- Inform the client of expected reactions to grief and loss (e.g., denial, fear)
- Provide the client with resources to adjust to loss/bereavement (e.g., individual counseling, support groups)
- Evaluate the client's coping and fears related to grief and loss

*Activity Statements used in the 2014 RN Practice Analysis

Mental Health Concepts

- Identify signs and symptoms of impaired cognition (e.g., memory loss, poor hygiene)
- Recognize signs and symptoms of acute and chronic mental illness (e.g., schizophrenia, depression, bipolar disorder)
- Recognize the client use of defense mechanisms
- Explore why client is refusing/not following treatment plan (e.g., non-adherence)
- Assess client for alterations in mood, judgment, cognition and reasoning
- Apply knowledge of client psychopathology to mental health concepts applied in individual/group/family therapy
- Provide care and education for acute and chronic psychosocial health issues (e.g., addictions/dependencies, depression, dementia, eating disorders)*
- Evaluate the client's ability to adhere to treatment plan
- Evaluate a client's abnormal response to the aging process (e.g., depression)

Religious and Spiritual Influences on Health

- Identify the emotional problems of client or client needs that are related to religious/spiritual beliefs (e.g., spiritual distress, conflict between recommended treatment and beliefs)
- Assess psychosocial, spiritual and occupational factors affecting care, and plan interventions*
- Assess and plan interventions that meet the client's emotional and spiritual needs
- Evaluate whether the client's religious/spiritual needs are met

Sensory/Perceptual Alterations

- Identify time, place, and stimuli surrounding the appearance of symptoms
- Assist client to develop strategies for dealing with sensory and thought disturbances
- Provide care for a client experiencing visual, auditory or cognitive distortions (e.g., hallucinations)*
- Provide care in a nonthreatening and nonjudgmental manner
- Provide reality-based diversions

Stress Management

- Recognize nonverbal cues to physical and/or psychological stressors*
- Assess stressors, including environmental, that affect client care (e.g., noise, fear, uncertainty, change, lack of knowledge)
- Implement measures to reduce environmental stressors (e.g., noise, temperature, pollution)
- Provide information to client on stress management techniques (e.g., relaxation techniques, exercise, meditation)
- Evaluate the client's use of stress management techniques

Support Systems

- Assist family to plan care for client with impaired cognition (e.g., Alzheimer's disease)
- Encourage the client's involvement in the health care decision-making process
- Evaluate the client's feelings about the diagnosis/treatment plan

*Activity Statements used in the 2014 RN Practice Analysis

Therapeutic Communication

- Assess verbal and nonverbal client communication needs
- Respect the client's personal values and beliefs
- Allow time to communicate with the client
- Use therapeutic communication techniques to provide client support*
- Encourage the client to verbalize feelings (e.g., fear, discomfort)
- Evaluate the effectiveness of communications with the client

Therapeutic Environment

- Identify external factors that may interfere with client recovery (e.g., stressors, family dynamics)
- Make client room assignments that support the therapeutic milieu
- Provide a therapeutic environment for clients*

Sample Item
The nurse is caring for a client who was brought to the emergency department (ED) by the spouse. Based on the client's injuries, the nurse suspects the client may have been physically abused. Which of the following actions would be **most** appropriate for the nurse to take? 1. Question the client about the possibility of abuse when the spouse is not in the room. **(key)** 2. Explain to the client that the client will have to speak with a police officer to rule out the possibility of abuse. 3. Explain to the spouse that the client's injuries appear to be the result of physical abuse. 4. Ask the client and the spouse how long they have been married.

*Activity Statements used in the 2014 RN Practice Analysis

Physiological Integrity

Basic Care and Comfort

- **Basic Care and Comfort** – the nurse provides comfort and assistance in the performance of activities of daily living.

BASIC CARE AND COMFORT **Related Activity Statements from the *2014 RN Practice Analysis: Linking the NCLEX-RN Examination to Practice***
▪ Assist client to compensate for a physical or sensory impairment (e.g., assistive devices, positioning, compensatory techniques) ▪ Assess and manage client with an alteration in elimination (e.g., bowel, urinary) ▪ Perform irrigations (e.g., of bladder, ear, eye) ▪ Perform skin assessment and implement measures to maintain skin integrity and prevent skin breakdown (e.g., turning, repositioning, pressure-relieving support surfaces) ▪ Apply, maintain or remove orthopedic devices (e.g., traction, splints, braces, casts) ▪ Apply and maintain devices used to promote venous return (e.g., anti-embolic stockings, sequential compression devices) ▪ Implement measures to promote circulation (e.g., active or passive range of motion, positioning and mobilization) ▪ Assess client need for pain management (e.g., light dimming, warm blanket) ▪ Provide non-pharmacological comfort measures ▪ Manage the client's nutritional intake (e.g., adjust diet, monitor height and weight) ▪ Provide client nutrition through continuous or intermittent tube feedings ▪ Evaluate client intake and output and intervene as needed ▪ Assess and intervene in client performance of activities of daily living ▪ Perform post-mortem care ▪ Assess client need for sleep/rest and intervene as needed ▪ Recognize complementary therapies and identify potential contraindications (e.g., aromatherapy, acupressure, supplements)

Related content includes, but is **not limited** to:

Assistive Devices

- Assess the client for actual/potential difficulty with communication and speech/vision/hearing problems
- Assess the client's use of assistive devices (e.g., prosthetic limbs, hearing aid)
- Assist client to compensate for a physical or sensory impairment (e.g., assistive devices, positioning, compensatory techniques)*
- Manage the client who uses assistive devices or prostheses (e.g., eating utensils, telecommunication devices, dentures)
- Evaluate the correct use of assistive devices by the client

*Activity Statements used in the 2014 RN Practice Analysis

Elimination

- Assess and manage client with an alteration in elimination (e.g., bowel, urinary)*
- Perform irrigations (e.g., of bladder, ear, eye)*
- Provide skin care to clients who are incontinent (e.g., wash frequently, barrier creams/ointments)
- Use alternative methods to promote voiding
- Evaluate whether the client's ability to eliminate is restored/maintained

Mobility/Immobility

- Identify complications of immobility (e.g., skin breakdown, contractures)
- Assess the client for mobility, gait, strength and motor skills
- Perform skin assessment and implement measures to maintain skin integrity and prevent skin breakdown (e.g., turning, repositioning, pressure-relieving support surfaces)*
- Apply knowledge of nursing procedures and psychomotor skills when providing care to clients with immobility
- Apply, maintain or remove orthopedic devices (e.g., traction, splints, braces, casts)*
- Apply and maintain devices used to promote venous return (e.g., anti-embolic stockings, sequential compression devices)*
- Educate the client regarding proper methods used when repositioning an immobilized client
- Maintain the client's correct body alignment
- Maintain/correct the adjustment of client's traction device (e.g., external fixation device, halo traction, skeletal traction)
- Implement measures to promote circulation (e.g., active or passive range of motion, positioning and mobilization)*
- Evaluate the client's response to interventions to prevent complications from immobility

Non-Pharmacological Comfort Interventions

- Assess the client's need for alternative and/or complementary therapy
- Assess the client's need for palliative care/symptom-management or non-curative treatments
- Assess client need for pain management*
- Recognize differences in client perception and response to pain
- Apply knowledge of pathophysiology to non-pharmacological comfort/palliative care interventions
- Incorporate alternative/complementary therapies into client plan of care (e.g., music therapy, relaxation therapy)
- Recognize complementary therapies and identify potential contraindications (e.g., aromatherapy, acupressure, supplements)*
- Counsel client regarding palliative/symptom-management, non-curative treatments or care choices
- Respect client palliative care/symptom-management or non-curative treatment choices
- Assist client in receiving appropriate end of life physical symptom management
- Plan measures to provide comfort interventions to clients with anticipated or actual impaired comfort

*Activity Statements used in the 2014 RN Practice Analysis

- Provide non-pharmacological comfort measures (e.g., light dimming, warm blanket)*
- Evaluate the client's response to non-pharmacological interventions (e.g., pain rating scale, verbal reports)
- Evaluate the outcomes of alternative and/or complementary therapy practices
- Evaluate outcome of palliative care/symptom-management or non-curative treatments interventions

Nutrition and Oral Hydration

- Assess client ability to eat (e.g., chew, swallow)
- Assess client for actual/potential specific food and medication interactions
- Consider client choices regarding meeting nutritional requirements and/or maintaining dietary restrictions, including mention of specific food items
- Monitor client hydration status (e.g., edema, signs and symptoms of dehydration)
- Initiate calorie counts for clients
- Apply knowledge of mathematics to client nutrition (e.g., body mass index [BMI])
- Manage the client's nutritional intake (e.g., adjust diet, monitor height and weight)*
- Promote the client's independence in eating
- Provide/maintain special diets based on the client diagnosis/nutritional needs and cultural considerations (e.g., low sodium, high protein, calorie restrictions)
- Provide nutritional supplements as needed (e.g., high protein drinks)
- Provide client nutrition through continuous or intermittent tube feedings*
- Evaluate side effects of client tube feedings and intervene, as needed (e.g., diarrhea, dehydration)
- Evaluate client intake and output and intervene as needed*
- Evaluate the impact of disease/illness on nutritional status of a client

Personal Hygiene

- Assess the client for personal hygiene habits/routine
- Assess and intervene in client performance of activities of daily living*
- Provide information to the client on required adaptations for performing activities of daily living (e.g., shower chair, hand rails)
- Perform post-mortem care*

Rest and Sleep

- Assess client need for sleep/rest and intervene as needed*
- Apply knowledge of client pathophysiology to rest and sleep interventions
- Schedule client care activities to promote adequate rest

*Activity Statements used in the 2014 RN Practice Analysis

Sample Item
The nurse is teaching a client with gastroesophageal reflux disease (GERD) about dietary and lifestyle modifications. Which of the following information should the nurse include in the teaching? **Select all that apply.** 1. Maintain a high-protein, low-fat diet. **(key)** 2. Avoid snacks between meals. 3. Sleep with the head of the bed elevated. **(key)** 4. Stay upright for 2 to 3 hours after eating. **(key)** 5. Decrease daily intake of sodium.

*Activity Statements used in the 2014 RN Practice Analysis

Pharmacological and Parenteral Therapies

- **Pharmacological and Parenteral Therapies** – the nurse provides care related to the administration of medications and parenteral therapies.

PHARMACOLOGICAL AND PARENTERAL THERAPIES **Related Activity Statements from the *2014 RN Practice Analysis: Linking the NCLEX-RN Examination to Practice***
▪ Administer blood products and evaluate client response ▪ Access venous access devices, including tunneled, implanted and central lines ▪ Perform calculations needed for medication administration ▪ Evaluate client response to medication (e.g., therapeutic effects, side effects, adverse reactions) ▪ Educate client about medications ▪ Prepare and administer medications, using rights of medication administration ▪ Review pertinent data prior to medication administration (e.g., contraindications, lab results, allergies, potential interactions) ▪ Participate in medication reconciliation process ▪ Titrate dosage of medication based on assessment and ordered parameters (e.g., giving insulin according to blood glucose levels, titrating medication to maintain a specific blood pressure) ▪ Evaluate appropriateness and accuracy of medication order for client ▪ Monitor intravenous infusion and maintain site (e.g., central, PICC, epidural and venous access devices) ▪ Administer pharmacological measures for pain management ▪ Administer controlled substances within regulatory guidelines (e.g., witness, waste) ▪ Administer parenteral nutrition and evaluate client response (e.g., TPN) ▪ Handle and maintain medication in a safe and controlled environment

Related content includes, but is **not limited** to:

Adverse Effects/Contraindications/Side Effects/Interactions

- Identify a contraindication to the administration of a medication to the client
- Identify actual and potential incompatibilities of prescribed client medications
- Identify symptoms/evidence of an allergic reaction (e.g., to medications)
- Assess the client for actual or potential side effects and adverse effects of medications (e.g., prescribed, over-the-counter, herbal supplements, preexisting condition)
- Provide information to the client on common side effects/adverse effects/potential interactions of medications and inform the client when to notify the primary health care provider
- Notify the primary health care provider of side effects, adverse effects and contraindications of medications and parenteral therapy
- Document side effects and adverse effects of medications and parenteral therapy

*Activity Statements used in the 2014 RN Practice Analysis

- Monitor for anticipated interactions among the client prescribed medications and fluids (e.g., oral, IV, subcutaneous, IM, topical prescriptions)
- Evaluate and document the client's response to actions taken to counteract side effects and adverse effects of medications and parenteral therapy

Blood and Blood Products

- Identify the client according to facility/agency policy prior to administration of red blood cells/ blood products (e.g., prescription for administration, correct type, correct client, cross matching complete, consent obtained)
- Check the client for appropriate venous access for red blood cell/blood product administration (e.g., correct gauge needle, integrity of access site)
- Document necessary information on the administration of red blood cells/blood products
- Administer blood products and evaluate client response*

Central Venous Access Devices

- Educate the client on the reason for and care of a venous access device
- Access venous access devices, including tunneled, implanted and central lines*
- Provide care for client with a central venous access device

Dosage Calculation

- Perform calculations needed for medication administration*
- Use clinical decision making/critical thinking when calculating dosages

Expected Actions/Outcomes

- Obtain information on a client's prescribed medications (e.g., review formulary, consult pharmacist)
- Use clinical decision making/critical thinking when addressing expected effects/outcomes of medications (e.g., oral, intradermal, subcutaneous, IM, topical)
- Evaluate the client's use of medications over time (e.g., prescription, over-the-counter, home remedies)
- Evaluate client response to medication (e.g., therapeutic effects, side effects, adverse reactions)*

Medication Administration

- Educate client about medications*
- Educate client on medication self-administration procedures
- Prepare and administer medications, using rights of medication administration*
- Review pertinent data prior to medication administration (e.g., contraindications, lab results, allergies, potential interactions)*
- Mix medications from two vials when necessary
- Administer and document medications given by common routes (e.g., oral, topical)
- Administer and document medications given by parenteral routes (e.g., intravenous, intramuscular, subcutaneous)
- Participate in medication reconciliation process*

*Activity Statements used in the 2014 RN Practice Analysis

- Titrate dosage of medication based on assessment and ordered parameters (e.g., giving insulin according to blood glucose levels, titrating medication to maintain a specific blood pressure)*
- Dispose of unused medications according to facility/agency policy
- Handle and maintain medication in a safe and controlled environment*
- Evaluate appropriateness and accuracy of medication order for client* (order/prescription)

Parenteral/Intravenous Therapies

- Identify appropriate veins that should be accessed for various therapies
- Educate client on the need for intermittent parenteral fluid therapy
- Apply knowledge and concepts of mathematics/nursing procedures/psychomotor skills when caring for a client receiving intravenous and parenteral therapy
- Prepare the client for intravenous catheter insertion
- Monitor the use of an infusion pump (e.g., IV, patient-controlled analgesia device)
- Monitor intravenous infusion and maintain site (e.g., central, peripheral, epidural and venous access devices)*
- Evaluate the client's response to intermittent parenteral fluid therapy

Pharmacological Pain Management

- Assess client need for administration of a PRN pain medication (e.g., oral, topical, subcutaneous, IM, IV)
- Administer and document pharmacological pain management appropriate for client age and diagnoses (e.g., pregnancy, children, older adults)
- Administer pharmacological measures for pain management*
- Administer controlled substances within regulatory guidelines (e.g., witness, waste)*
- Evaluate and document the client's use and response to pain medications

Total Parenteral Nutrition (TPN)

- Identify side effects/adverse events related to TPN and intervene as appropriate (e.g., hyperglycemia, fluid imbalance, infection)
- Educate client on the need for and use of TPN
- Apply knowledge of nursing procedures and psychomotor skills when caring for a client receiving TPN
- Apply knowledge of client pathophysiology and mathematics to TPN interventions
- Administer parenteral nutrition and evaluate client response (e.g., TPN)*

*Activity Statements used in the 2014 RN Practice Analysis

Sample Item
The nurse is caring for a client who has a prescription for gentamicin 2 mg/kg, IV, every 8 hours. The client weighs 143 lbs. (65 kg). The nurse has gentamicin 100 mg in 50 ml of solution available. How many ml should the nurse administer to the client with each dose? Record your answer using a whole number. 65 ml **(key)**

*Activity Statements used in the 2014 RN Practice Analysis

Reduction of Risk Potential

- **Reduction of Risk Potential** – the nurse reduces the likelihood that clients will develop complications or health problems related to existing conditions, treatments or procedures.

REDUCTION OF RISK POTENTIAL **Related Activity Statements from the *2014 RN Practice Analysis: Linking the NCLEX-RN Examination to Practice***
▪ Assess and respond to changes in client vital signs ▪ Perform diagnostic testing (e.g., electrocardiogram, oxygen saturation, glucose monitoring) ▪ Monitor the results of diagnostic testing and intervene as needed ▪ Obtain blood specimens peripherally or through central line ▪ Obtain specimens other than blood for diagnostic testing (e.g., wound, stool, urine) ▪ Insert, maintain and remove a gastric tube ▪ Insert, maintain and remove a urinary catheter ▪ Insert, maintain and remove a peripheral intravenous line ▪ Use precautions to prevent injury and/or complications associated with a procedure or diagnosis ▪ Evaluate responses to procedures and treatments ▪ Recognize trends and changes in client condition and intervene as needed ▪ Perform focused assessment ▪ Educate client about treatments and procedures ▪ Provide preoperative and postoperative education ▪ Provide preoperative care ▪ Manage client during and/or following a procedure with moderate sedation

Related content includes, but is **not limited** to:

Changes/Abnormalities in Vital Signs

- Assess and respond to changes in client vital signs*
- Apply knowledge needed to perform related nursing procedures and psychomotor skills when assessing vital signs
- Apply knowledge of client pathophysiology when measuring vital signs
- Evaluate invasive monitoring data (e.g., pulmonary artery pressure, intracranial pressure)

Diagnostic Tests

- Apply knowledge of related nursing procedures and psychomotor skills when caring for clients undergoing diagnostic testing
- Compare client diagnostic findings with pre-test results

*Activity Statements used in the 2014 RN Practice Analysis

- Perform diagnostic testing (e.g., electrocardiogram, oxygen saturation, glucose monitoring)*
- Perform fetal heart monitoring
- Monitor results of maternal and fetal diagnostic tests (e.g., non-stress test, amniocentesis, ultrasound)
- Monitor the results of diagnostic testing and intervene as needed*

Laboratory Values

- Identify laboratory values for ABGs (pH, PO_2, PCO_2, SaO_2, HCO_3), BUN, cholesterol (total) glucose, hematocrit, hemoglobin, glycosylated hemoglobin ($HgbA_1C$), platelets, potassium, sodium, WBC, creatinine, PT, PTT & APTT, INR
- Compare client laboratory values to normal laboratory values
- Educate client about the purpose and procedure of prescribed laboratory tests
- Obtain blood specimens peripherally or through central line*
- Obtain specimens other than blood for diagnostic testing (e.g., wound, stool, urine)*
- Monitor client laboratory values (e.g., glucose testing results for the client with diabetes)
- Notify primary health care provider about laboratory test results

Potential for Alterations in Body Systems

- Identify client potential for aspiration (e.g., feeding tube, sedation, swallowing difficulties)
- Identify client potential for skin breakdown (e.g., immobility, nutritional status, incontinence)
- Identify client with increased risk for insufficient vascular perfusion (e.g., immobilized limb, post surgery, diabetes)
- Educate client on methods to prevent complications associated with activity level/diagnosed illness/disease (e.g., contractures, foot care for client with diabetes mellitus)
- Compare current client data to baseline client data (e.g., symptoms of illness/disease)
- Monitor client output for changes from baseline (e.g., nasogastric [NG] tube, emesis, stools, urine)

Potential for Complications of Diagnostic Tests/Treatments/Procedures

- Assess client for an abnormal response following a diagnostic test/procedure (e.g., dysrhythmia following cardiac catheterization)
- Apply knowledge of nursing procedures and psychomotor skills when caring for a client with potential for complications
- Monitor the client for signs of bleeding
- Position the client to prevent complications following tests/treatments/procedures (e.g., elevate head of bed, immobilize extremity)
- Insert, maintain and remove a gastric tube*
- Insert, maintain and remove a urinary catheter*
- Insert, maintain and remove a peripheral intravenous line*
- Maintain tube patency (e.g., NG tube for decompression, chest tubes)

*Activity Statements used in the 2014 RN Practice Analysis

- Use precautions to prevent injury and/or complications associated with a procedure or diagnosis*
- Provide care for client undergoing electroconvulsive therapy (e.g., monitor airway, assess for side effects, teach client about procedure)
- Intervene to manage potential circulatory complications (e.g., hemorrhage, embolus, shock)
- Intervene to prevent aspiration (e.g., check NG tube placement)
- Intervene to prevent potential neurological complications (e.g., foot drop, numbness, tingling)
- Evaluate responses to procedures and treatments*

Potential for Complications from Surgical Procedures and Health Alterations

- Apply knowledge of pathophysiology to monitoring for complications (e.g., recognize signs of thrombocytopenia)
- Evaluate the client's response to post-operative interventions to prevent complications (e.g., prevent aspiration, promote venous return, promote mobility)

System Specific Assessments

- Assess the client for abnormal peripheral pulses after a procedure or treatment
- Assess the client for abnormal neurological status (e.g., level of consciousness, muscle strength, mobility)
- Assess the client for peripheral edema
- Assess the client for signs of hypoglycemia or hyperglycemia
- Identify factors that result in delayed wound healing
- Recognize trends and changes in client condition and intervene as needed*
- Perform a risk assessment (e.g., sensory impairment, potential for falls, level of mobility, skin integrity)
- Perform focused assessment*

Therapeutic Procedures

- Assess client response to recovery from local, regional or general anesthesia
- Apply knowledge of related nursing procedures and psychomotor skills when caring for clients undergoing therapeutic procedures
- Educate client about treatments and procedures*
- Educate client about home management of care (tracheostomy and ostomy)
- Use precautions to prevent further injury when moving a client with a musculoskeletal condition (e.g., log-rolling, abduction pillow)
- Monitor the client before, during, and after a procedure/surgery (e.g., casted extremity)
- Monitor effective functioning of therapeutic devices (e.g., chest tube, drainage tubes, wound drainage devices, continuous bladder irrigation)
- Provide preoperative and postoperative education*
- Provide preoperative care*
- Manage client during and/or following a procedure with moderate sedation*

*Activity Statements used in the 2014 RN Practice Analysis

Sample Item
The nurse has taught a client who is scheduled for a colonoscopy. Which of the following statements by the client would require follow up? 1. "I will not be able to eat or drink anything for 24 hours before the procedure." **(key)** 2. "I may experience abdominal cramping after the procedure." 3. "I will be sedated during the procedure." 4. "I will be placed in the knee-chest position for the procedure."

*Activity Statements used in the 2014 RN Practice Analysis

Physiological Adaptation

- **Physiological Adaptation** – the nurse manages and provides care for clients with acute, chronic or life threatening physical health conditions.

PHYSIOLOGICAL ADAPTATION **Related Activity Statements from the *2014 RN Practice Analysis: Linking the NCLEX-RN Examination to Practice***
▪ Assist with invasive procedures (e.g., central line, thoracentesis, bronchoscopy) ▪ Implement and monitor phototherapy ▪ Maintain optimal temperature of client (e.g., cooling and/or warming blanket) ▪ Monitor and care for clients on a ventilator ▪ Monitor and maintain devices and equipment used for drainage (e.g., surgical wound drains, chest tube suction, negative pressure wound therapy) ▪ Perform and manage care of client receiving peritoneal dialysis ▪ Perform suctioning (e.g., oral, nasopharyngeal, endotracheal, tracheal) ▪ Provide wound care or dressing change ▪ Provide ostomy care and education (e.g., tracheal, enteral) ▪ Provide pulmonary hygiene (e.g., chest physiotherapy, incentive spirometry) ▪ Provide postoperative care ▪ Manage the care of the client with a fluid and electrolyte imbalance ▪ Monitor and maintain arterial lines ▪ Manage the care of a client with a pacing device (e.g., pacemaker) ▪ Manage the care of a client on telemetry ▪ Manage the care of a client receiving hemodialysis or continuous renal replacement therapy ▪ Manage the care of a client with alteration in hemodynamics, tissue perfusion and hemostasis (e.g., cerebral, cardiac, peripheral) ▪ Educate client regarding an acute or chronic condition ▪ Manage the care of a client with impaired ventilation/oxygenation ▪ Evaluate the effectiveness of the treatment regimen for a client with an acute or chronic diagnosis ▪ Perform emergency care procedures (e.g., cardio-pulmonary resuscitation, respiratory support, automated external defibrillator) ▪ Identify pathophysiology related to an acute or chronic condition (e.g., signs and symptoms) ▪ Recognize signs and symptoms of complications and intervene appropriately when providing client care

Related content includes, but is **not limited** to:

Alterations in Body Systems

- Assess adaptation of a client to health alteration, illness and/or disease
- Assess tube drainage during the time the client has an alteration in body systems (e.g., amount, color)
- Assess client for signs and symptoms of adverse effects of radiation therapy
- Identify signs of potential prenatal complications
- Identify signs, symptoms and incubation periods of infectious diseases
- Apply knowledge of nursing procedures, pathophysiology and psychomotor skills when caring for a client with an alteration in body systems
- Educate client about managing health problems (e.g., chronic illness)
- Assist with invasive procedures (e.g., central line, thoracentesis, bronchoscopy)*
- Implement and monitor phototherapy*
- Implement interventions to address side/adverse effects of radiation therapy (e.g., dietary modifications, avoid sunlight)
- Maintain optimal temperature of client (e.g., cooling and/or warming blanket)*
- Monitor and care for clients on a ventilator*
- Monitor wounds for signs and symptoms of infection
- Monitor and maintain devices and equipment used for drainage (e.g., surgical wound drains, chest tube suction, negative pressure wound therapy)*
- Perform and manage care of client receiving peritoneal dialysis*
- Perform suctioning (e.g., oral, nasopharyngeal, endotracheal, tracheal)*
- Perform wound care or dressing change*
- Promote client progress toward recovery from an alteration in body systems
- Provide ostomy care and education (e.g., tracheal, enteral)*
- Provide care to client who has experienced a seizure
- Provide care to a client with an infectious disease
- Provide pulmonary hygiene (e.g., chest physiotherapy, incentive spirometry)*
- Provide care for client experiencing complications of pregnancy/labor and/or delivery (e.g., eclampsia, precipitous labor, hemorrhage)
- Provide care for client experiencing increased intracranial pressure
- Provide postoperative care*
- Remove sutures or staples
- Evaluate client response to surgery
- Evaluate achievement of client treatment goals
- Evaluate client response to treatment for an infectious disease (e.g., acquired immune deficiency syndrome [AIDS], tuberculosis [TB])
- Evaluate and monitor client response to radiation therapy

*Activity Statements used in the 2014 RN Practice Analysis

Fluid and Electrolyte Imbalances

- Identify signs and symptoms of client fluid and/or electrolyte imbalance
- Apply knowledge of pathophysiology when caring for the client with fluid and electrolyte imbalances
- Manage the care of the client with a fluid and electrolyte imbalance*
- Evaluate the client's response to interventions to correct fluid or electrolyte imbalance

Hemodynamics

- Assess client for decreased cardiac output (e.g., diminished peripheral pulses, hypotension)
- Identify cardiac rhythm strip abnormalities (e.g., sinus bradycardia, premature ventricular contractions [PVCs], ventricular tachycardia, fibrillation)
- Apply knowledge of pathophysiology to interventions in response to client abnormal hemodynamics
- Provide client with strategies to manage decreased cardiac output (e.g., frequent rest periods, limit activities)
- Intervene to improve client cardiovascular status (e.g., initiate protocol to manage cardiac arrhythmias, monitor pacemaker functions)
- Monitor and maintain arterial lines*
- Manage the care of a client with a pacing device (e.g., pacemaker)*
- Manage the care of a client on telemetry*
- Manage the care of a client receiving hemodialysis or continuous renal replacement therapy*
- Manage the care of a client with alteration in hemodynamics, tissue perfusion and hemostasis (e.g., cerebral, cardiac, peripheral)*

Illness Management

- Identify client data that needs to be reported immediately
- Apply knowledge of client pathophysiology to illness management
- Educate client regarding an acute or chronic condition*
- Educate client about managing illness (e.g., acquired immune deficiency syndrome [AIDS], chronic illnesses)
- Implement interventions to manage the client's recovery from an illness
- Perform gastric lavage
- Promote and provide continuity of care in illness management activities (e.g., cast placement)
- Manage the care of a client with impaired ventilation/oxygenation*
- Evaluate the effectiveness of the treatment regimen for a client with an acute or chronic diagnosis*

Medical Emergencies

- Apply knowledge of pathophysiology when caring for a client experiencing a medical emergency
- Apply knowledge of nursing procedures and psychomotor skills when caring for a client experiencing a medical emergency

*Activity Statements used in the 2014 RN Practice Analysis

- Explain emergency interventions to a client
- Notify primary health care provider about client unexpected response/emergency situation
- Perform emergency care procedures (e.g., cardio-pulmonary resuscitation, respiratory support, automated external defibrillator)*
- Provide emergency care for wound disruption (e.g., evisceration, dehiscence)
- Evaluate and document the client's response to emergency interventions (e.g., restoration of breathing, pulse)

Pathophysiology

- Identify pathophysiology related to an acute or chronic condition (e.g., signs and symptoms)*
- Understand general principles of pathophysiology (e.g., injury and repair, immunity, cellular structure)

Unexpected Response to Therapies

- Assess the client for unexpected adverse response to therapy (e.g., increased intracranial pressure, hemorrhage)
- Recognize signs and symptoms of complications and intervene appropriately when providing client care*
- Promote recovery of the client from unexpected response to therapy (e.g., urinary tract infection)

Sample Item
The nurse is assessing a client with hyperthyroidism. Which of the following findings would the nurse expect to observe? **Select all that apply.** 1. increased appetite **(key)** 2. lethargy 3. diarrhea **(key)** 4. exopthalmos **(key)** 5. weight gain 6. cold intolerance

*Activity Statements used in the 2014 RN Practice Analysis

IV. Administration of the NCLEX-RN® Examination

Examination Length

The NCLEX-RN® examination is a variable length computerized adaptive test. It is not offered in paper-and-pencil or oral examination formats and can be anywhere from 75 to 265 items long. Of these items, 15 are pretest items that are not scored. The time limit for the exam is specified in the candidate bulletin. It is important to note that the time allotted for the examination **includes** the tutorial, sample items, all breaks (restroom, stretching, etc.), and the examination. All breaks are optional.

The length of the examination is determined by the candidate's responses to the items. After the minimum number of items has been answered, testing stops when the candidate's ability is determined to be either above or below the passing standard with 95 percent certainty. Depending upon the particular pattern of correct and incorrect responses, different candidates will take different numbers of items and therefore use varying amounts of time. The examination will stop when the maximum number of items has been taken or when the time limit has been reached. Remember, it is in the candidate's best interest to maintain a reasonable pace of spending only one or two minutes on each item. The candidates should select a pace that will permit them to complete the examination within the allotted time should the maximum number of items be administered.

It is important to understand that the length of the candidate's examination is not an indication of a pass or fail result. A candidate with a relatively short examination may pass or fail just as the candidate with a long examination may pass or fail. Regardless of the length of the examination, each candidate is given an examination that conforms to the NCLEX test plan and has ample opportunity to demonstrate his or her ability.

The Passing Standard

The NCSBN Board of Directors (BOD) reevaluates the passing standard once every three years. The criterion that the BOD uses to set the standard is the minimum level of ability required for safe and effective entry-level nursing practice.

To assist the BOD in making this decision, they are provided with information on:

1. The results of a standard setting exercise performed by a panel of experts with the assistance of professional psychometricians;
2. The historical record of the passing standard with summaries of the candidate performance associated with those standards;
3. The results of a standard setting survey sent to educators and employers; and
4. Information describing the educational readiness of high school graduates who express an interest in nursing

Once the passing standard is set, it is imposed uniformly on every test record according to the procedures laid out in the Scoring the NCLEX section. To pass an NCLEX examination, a candidate must perform **above** the passing standard. There is no fixed percentage of candidates that pass or fail each examination.

Similar Items

Occasionally, a candidate may receive an item that seems to be very similar to an item received earlier in the examination. This could happen for a variety of reasons. For example, several items could be about similar symptoms, diseases, or disorders, yet address different phases of the nursing process. Alternatively, a pretest (unscored) item could be about content similar to an operational (scored) item. It is **incorrect** to assume that a second item, which is similar in content to a previously administered item, is administered because the candidate answered the first item incorrectly. The candidate is instructed to always select the answer believed to be correct for each item administered. All examinations conform to their respective test plan.

Reviewing Answers and Guessing

The items are presented to the candidate one at a time on a computer screen. Each item can be viewed as long as the candidate likes, but it is not possible to go back to a previous item once the answer is selected and confirmed by pressing the <NEXT> button. Every item must be answered even if the candidate is not sure of the right answer. The computer will not allow the candidate to go on to the next item without answering the one on the screen. If the candidate is unsure of the correct answer, the best guess is made and the candidate moves on to the next item. After an answer to an item is selected, the candidate has a chance to think about the answer and change it if necessary. However, once the candidate confirms the answer and goes on to the next item, the candidate will not be allowed to go back to any previous item on the examination.

Please note that rapid guessing can drastically lower the score. Some test preparation companies have realized that on certain pencil and paper tests, unanswered items are marked as wrong. To improve the candidate's score when they are running out of time, these companies sometimes advocate rapid guessing (perhaps without even reading the item) in the hope that the candidate will get at least a few items correct. On any adaptive test, this can be disastrous. It has the effect of giving the candidate easier items which he or she will likely also get wrong. The best advice is to (1) maintain a reasonable pace, perhaps one item every minute or two; and (2) carefully read and consider each item before answering.

Scoring the NCLEX®

Computerized Adaptive Testing (CAT)

The NCLEX is different than a traditional pencil and paper examination. Typically, pencil and paper examinations administer the same items to every candidate, thus ensuring that the difficulty of the examination is the same across the board. Because the difficulty of the examination is constant, the percentage correct is the indicator of the candidate's ability. One disadvantage of this approach is that it is inefficient. It requires the high ability candidates to answer all of the easy items on the examination, which provides very little information about his or her ability. Another disadvantage is that guessing can artificially inflate the scores of low ability candidates, because they can answer these items correctly 25 percent of the time for reasons that have nothing to do with his or her ability.

Instead, the NCLEX uses CAT to administer the items. CAT is able to produce exam results that are more stable using fewer items by targeting items to the candidate's ability. The computer's goal during the NCLEX is to determine the ability of the candidate in relation to the passing standard. Every time the candidate answers an item, the computer re-estimates the candidate's ability. With each additional answered item, the ability estimate becomes more precise.

Each item that the candidate receives is selected from a large pool of items using three criteria:

1. The item is limited to the content area that will produce the best match to the test plan percentages. It is ensured that each candidate's exam has enough questions from each content area to match the required test plan percentages.
2. An item is selected that the candidate is expected to find challenging. Based on the candidate's answers up to that point and the difficulty of those items, the computer estimates the candidate's ability and selects an item that the candidate should have a 50 percent chance of answering correctly. This way, the next item should not be too easy or too hard and the examination can get maximum information about the candidate's ability from the item.
3. Excludes any item that a repeat candidate has seen in the last year.

Pretest Items

For CAT to work, the difficulty of each item must be known in advance. The degree of difficulty is determined by administering the items as pretest items to a large sample of NCLEX candidates. Because the difficulty of these pretest items is not known in advance, these items are not included when estimating the candidate's ability or making pass-fail decisions. When enough responses are collected, the pretest items are statistically analyzed and calibrated. If the pretest items meet the NCLEX statistical standards, they can be administered in future examinations as scored items. There are 15 pretest items on every NCLEX-RN examination. It is impossible to distinguish operational items from pretest items, so candidates are asked to do their best on every item.

Passing and Failing

The decision as to whether a candidate passes or fails the NCLEX is governed by three different scenarios:

Scenario 1: The 95% Confidence Interval Rule

This scenario is the most common for NCLEX candidates. The computer will stop administering items when it is 95% certain that the candidate's ability is either clearly above or clearly below the passing standard.

Scenario 2: Maximum-Length Exam

Some candidate's ability levels will be very close to the passing standard. When this is the case, the computer continues to administer questions until the maximum number of items is reached. At this point, the computer disregards the 95% confidence rule and considers only the final ability estimate:

- If the final ability estimate is above the passing standard, the candidate passes.
- If the final ability estimate is at or below the passing standard, the candidate fails.

Scenario 3: Run-Out-Of-Time Rule (R.O.O.T.)

If a candidate runs out of time before reaching the maximum number of items and the computer has not determined with 95% certainty whether the candidate has passed or failed, an alternate criteria is used.

- If the candidate has not answered the minimum number of required items, the candidate automatically fails.
- If at least the minimum number of required items were answered, the computer looks at the last 60 ability estimates.
    - If the last 60 ability estimates were consistently above the passing standard, the candidate passes.
    - If the candidate's ability estimate drops below the passing standard even once over the last 60 items, the candidate fails.

This does not mean that the candidate must answer the last 60 items correctly. Each ability estimate is based upon all previous items answered.

Scoring Items

The majority of items in the NCLEX are multiple-choice, but there are other formats as well. Items are scored as either right or wrong. There is no partial credit. For updated information on the administration of the examination, access the NCSBN website at www.ncsbn.org.

Types of Items on the NCLEX-RN® Examination

During the administration of the NCLEX-RN examination candidates will be required to respond to items in a variety of formats. These formats may include, but are not limited to: multiple-choice, multiple response, fill-in-the-blank calculation, ordered response, and/or hot spots. All item types may include multimedia, such as charts, tables, graphics, sound and video.

For more information, please visit the NCSBN website at www.ncsbn.org to review the information about Alternate Item Formats.

NCLEX® Examination Terminology

Client: Individual, family or group which includes significant others and population.

Prescription: Orders, interventions, remedies or treatments ordered or directed by an authorized primary health care provider.

Primary Health Care Provider: Member of the healthcare team (usually a medical physician [or other specialty, e.g., surgeon, nephrologist, etc.], nurse practitioner, etc.), licensed and authorized to formulate orders/ prescriptions on behalf of the client.

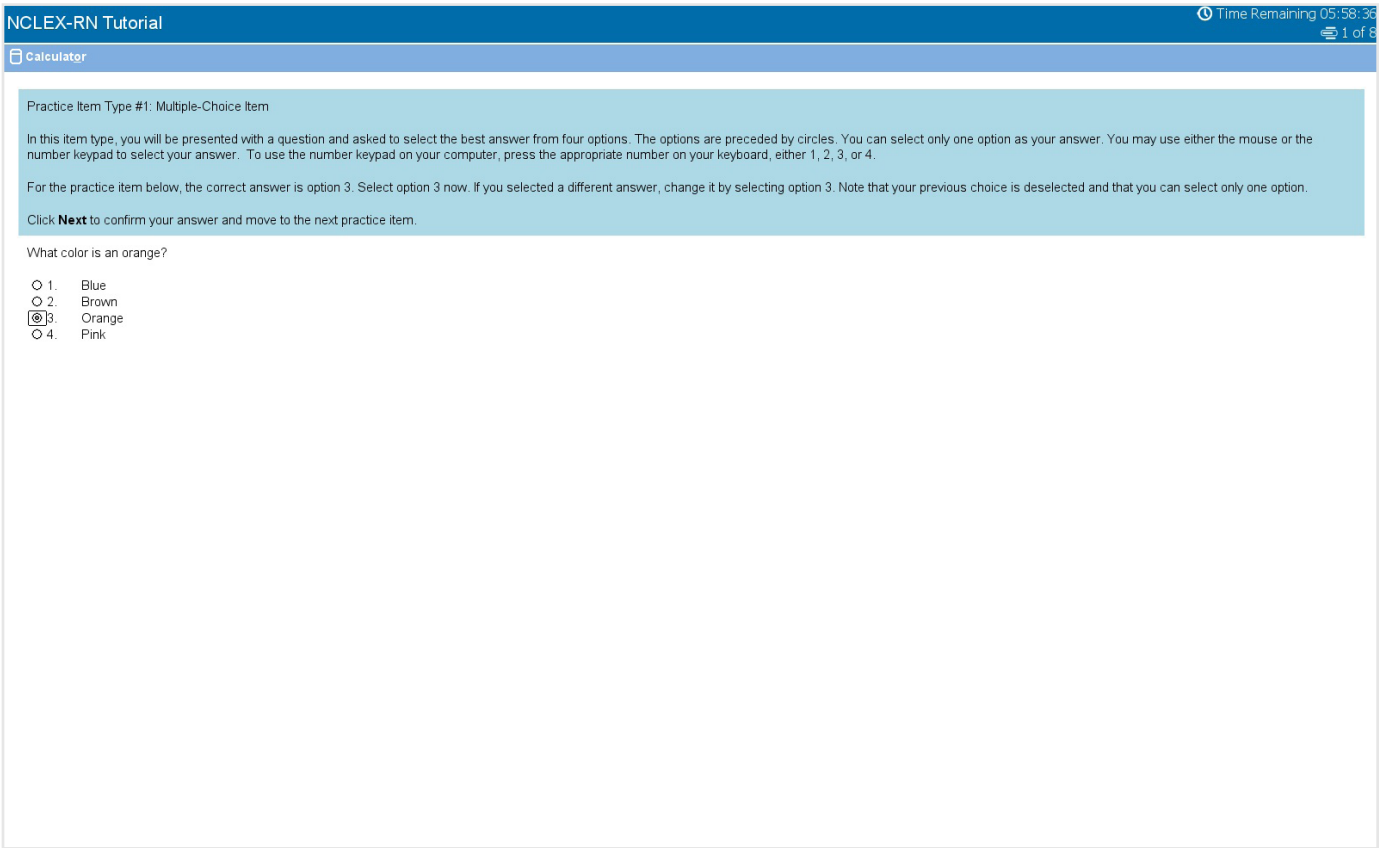
Confidentiality

Candidates should be aware and understand that the disclosure of examination items before, during, or after the examination is a violation of law. Violations of confidentiality and/or candidates' rules can result in criminal prosecution or civil liability and/or disciplinary actions by the licensing agency including the denial of licensure.

Tutorial

Each NCLEX-RN candidate is provided information on how to answer examination items. A tutorial is given at the beginning of the examination explaining the various formats that candidates may see on the examination. More information on alternate item formats is available at the NCSBN website at www.ncsbn.org. The following are examples of how screens in the tutorial may appear. Examples of possible item formats include:

Multiple Choice (One Answer):



Multiple Response:

NCLEX-RN Tutorial

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Calculator

Practice Item Type #2: Multiple-Response Item

In this item type, you will be presented with a question and a list of options and asked to select all the options that apply. Note that there may be two or more correct answers. You must select all options that apply.

Note how this item type differs from the single-response multiple-choice item you saw earlier. In this item type, the options are preceded by square boxes and you can check more than one box. In the previous item type, the options are circles and you can only select one option.

For the practice item below, the correct options are *Apple* and *Banana* (options 1 and 2). Please use your mouse to check *Apple* and *Banana* now. The check mark indicates that you have selected that response option. To deselect the response, click on the box again. The check mark will disappear, indicating that you have deselected that response.

Click **Next** to confirm your answer and move to the next practice item.

Which of the following are fruits? **Select all that apply.**

- ☑ 1. Apple
- ☑ 2. Banana
- ☐ 3. Cow
- ☐ 4. Dog
- ☐ 5. Elephant

Previous Next

Fill-in-the-Blank:

NCLEX-RN Tutorial - Candidate Name

Time Remaining 05:59:43

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Calculator

Practice Item Type #3: Fill-in-the-Blank Item

In this item type, you will be presented with a question and asked to calculate and type in your answer. Type only a number as your answer, including a decimal point if appropriate. To change your answer, use the backspace key to delete the number and type another number. **You will only be able to type in numbers as your answer. If you try to type any other characters, you will be presented with a message box asking you to try again.**

To use the calculator, click on the calculator button on the upper left-hand corner of the screen. To enter numbers in the calculator, you can use the mouse to click on the calculator's buttons or use the number keypad on your keyboard. When you are finished with the calculator, you can close the calculator by clicking on the X in the top right corner of the calculator.

For the practice item below, first open the calculator. Second, compute a total weight by adding the weight of four pumpkins. Third, compute the average by dividing the total weight by the number of pumpkins (4). The division symbol is ÷. Your calculator should now read 3.775.

You do not have to type in the unit of measurement, "kilograms" in this example. **If rounding is necessary, perform the rounding at the end of the calculation.** Please type 3.8 as your answer.

Click **Next** to confirm your answer and move to the next practice item.

The weights of four pumpkins in kilograms are: 4.22, 4.15, 3.40, 3.33. What is the average (mean) of the pumpkins' weight? Record your answer using one decimal place.

Answer: 3.8 kilograms

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Hot Spot:

NCLEX-RN Tutorial

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Calculator

Practice Item Type #4: Hot Spot Item

In this item type, you will be presented with a problem and a figure. You will be asked to use the mouse to select an area of the figure. To select an area, place the cursor on the area you want to select, then click on the left mouse button. An X will appear to show your answer. To deselect your answer, place the cursor on the X and click again. Your answer will be deselected. To change your answer, point the cursor to another area and click.

For the practice item below, the correct answer is Box 1. Use the mouse to select Box 1.

Click **Next** to confirm your answer and move to the next practice item.

The following figure contains four boxes. Which box is in the upper left-hand corner?

Box 1	Box 2
Box 3	Box 4

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Exhibit Item:

NCLEX-RN Tutorial

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5 of 8

Calculator

Practice Item Type #5: Exhibit Item

In this item type, you will be presented with a problem and an exhibit. To view the exhibit, click on the exhibit button. Each exhibit contains information behind three tabs. Click on each tab to read the information presented.

For the practice item below, the exhibit should contain the three tabs. Each tab contains the monthly receipts for purchasing bakery supplies:

- Storage/Packaging Materials
- Baking Ingredients
- Miscellaneous Supplies

The question asks you to find the most expensive item that is listed in the exhibit. The most expensive item is the storage bin, which is on the storage/packaging materials list. Therefore, option 2 below is the correct answer.

Click **Next** to confirm your answer and move to the next practice item.

Exhibit

The owner of a bakery would like to know which of the supplies is most expensive. Based upon receipts from the past month, which item was the most expensive? Click the exhibit button for additional information.

- 1. baking trays
- 2. storage bin
- 3. flour
- 4. pastry bags

Exhibit

Storage/Packaging Materials | Baking Ingredients | Miscellaneous Supplies

Storage/Packaging

Item	Charge
10" cake boxes	$55.00
Paper bags - large	$20.85
Bread bags	$25.50
Package labels	$10.99
Storage bin	$175.00
TOTAL	$287.34

Close

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Drag and Drop/Ordered Response Item:

NCLEX-RN Tutorial

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Calculator

Practice Item Type #6: Drag and Drop/Ordered Response Item

In this item type, you will be presented with a problem and a list of options. You will be asked to place the options in a specified order, such as numerical, alphabetical or chronological.

The unordered options will appear in a box on the left side of your screen. To place the options in a new order, click on an option and drag it to the box on the right side of your screen. You may also highlight the option in the left-hand box and then click the right arrow key to move the option. To rearrange the order of options once they have been placed in the right-hand box, select the option you would like to move and click the up or down arrow keys. You may also click an option and drag it to a new position within the right-hand box. To complete the item, you must move all options from the left-hand box to the right-hand box.

For the practice item below, you should move the list of months (by dragging or using the arrow button) to the right so that the list is in alphabetical order: April, February, January, June, March, May. That is, April should be at the top, and May should be at the bottom. If you do not have the months in this order, please re-arrange them now.

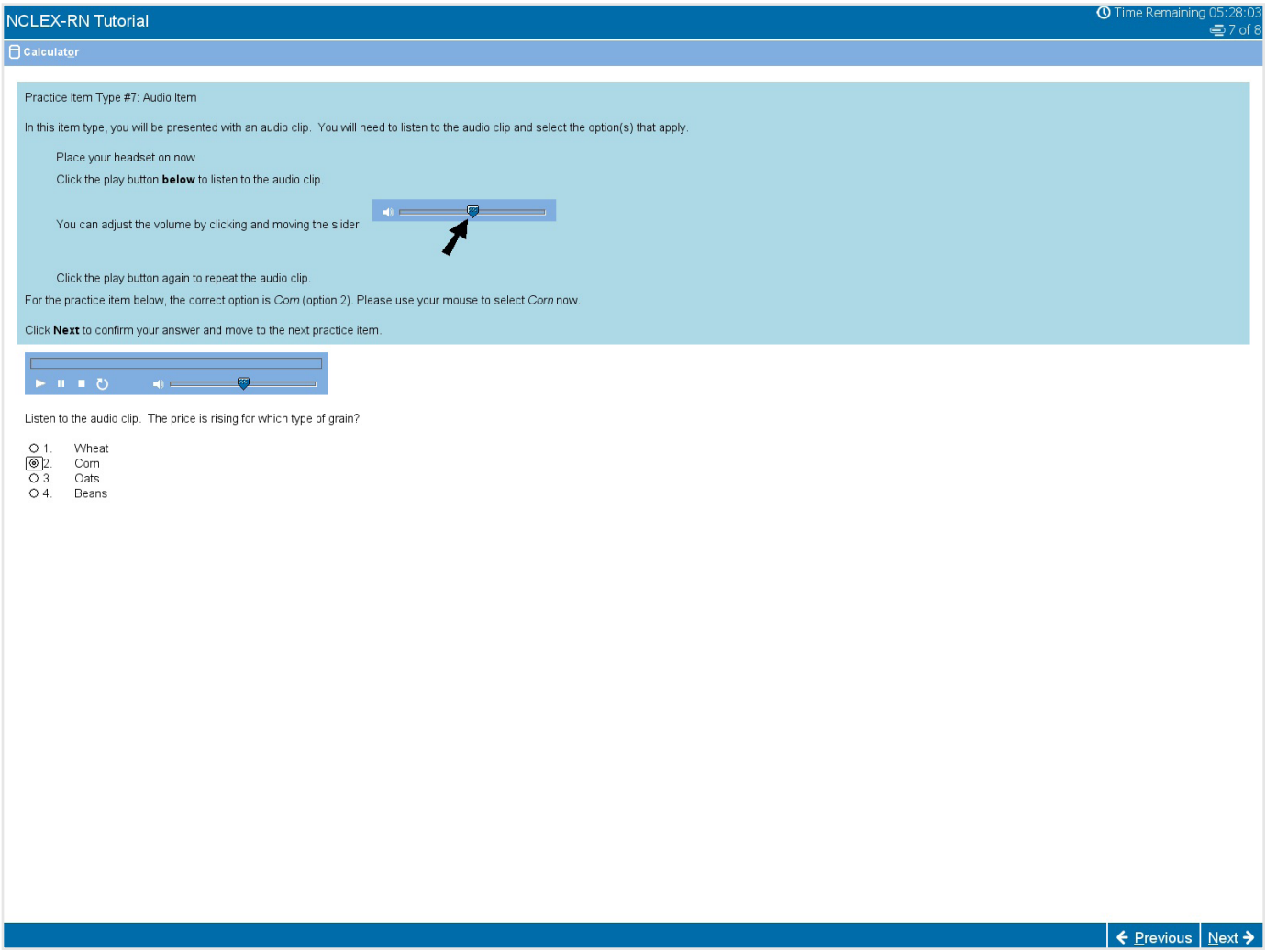
Click Next to confirm your answer and proceed.

The first six months of the year appear in a list below. Please arrange these months in alphabetical order. All options must be used.

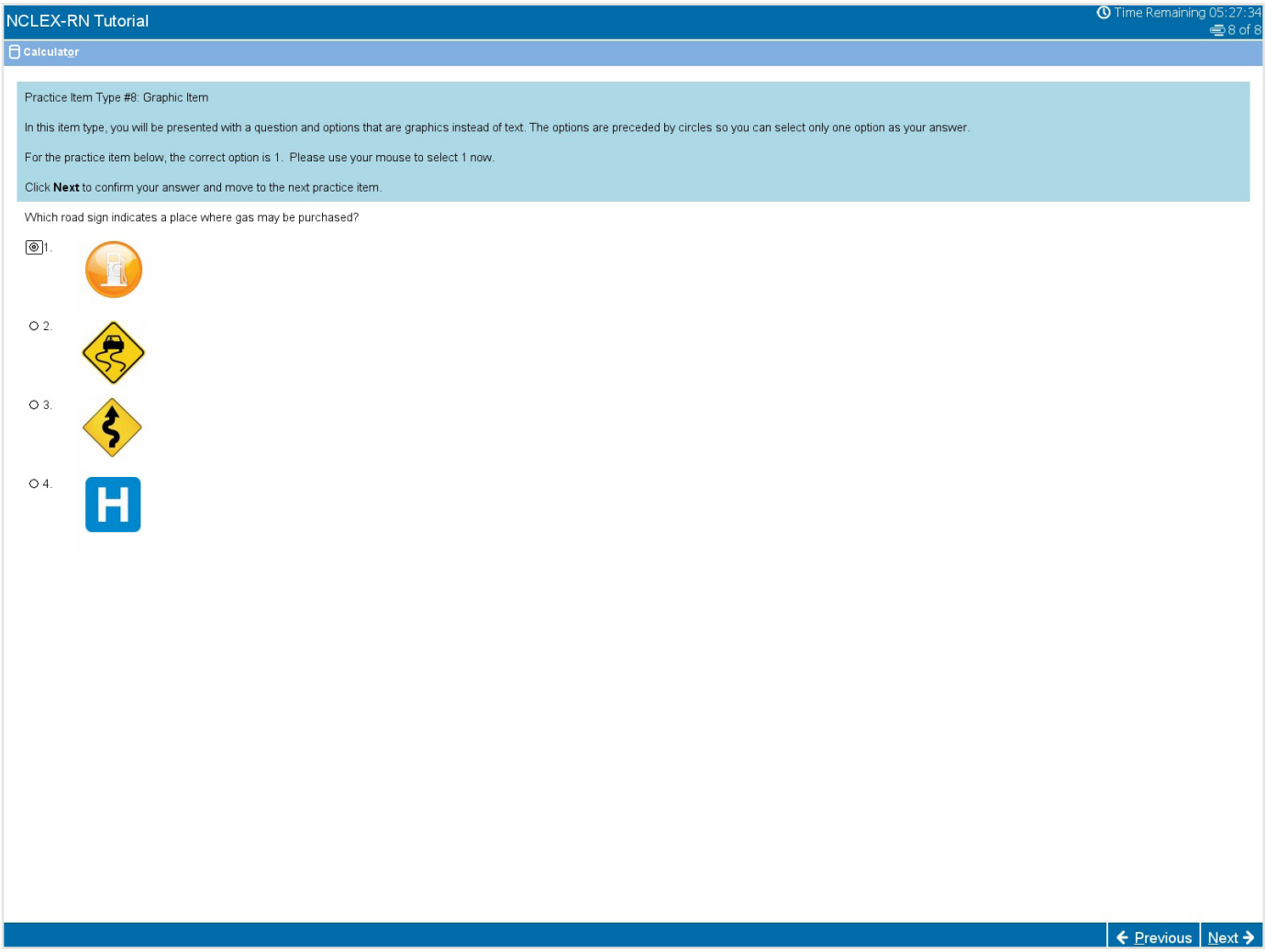
Unordered Options	Ordered Response
May	April
	February
	January
	June
	March

Previous Next

Audio Item:


NCLEX-RN Tutorial
Time Remaining 05:28:03
7 of 8
Calculator
Practice Item Type #7: Audio Item
In this item type, you will be presented with an audio clip. You will need to listen to the audio clip and select the option(s) that apply.
Place your headset on now.
Click the play button **below** to listen to the audio clip.
You can adjust the volume by clicking and moving the slider.
Click the play button again to repeat the audio clip.
For the practice item below, the correct option is *Corn* (option 2). Please use your mouse to select *Corn* now.
Click **Next** to confirm your answer and move to the next practice item.
Listen to the audio clip. The price is rising for which type of grain?
1. Wheat
2. Corn
3. Oats
4. Beans
Previous
Next

Graphic Item:



To receive updated information, visit the NCSBN website at www.ncsbn.org.

VI. References

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